Executive Summary

One hundred and fifty years ago, the "first citizens" of our state inhabited thriving and self-sustaining communities throughout our magnificent territory. Today, many American Indians are now among the poorest of our citizens. Poor health also is a companion of this poverty. The American Indian Health Care Delivery Plan is a cooperative effort of the state and the tribes to address this long-neglected problem and to develop strategies that will improve the health status of our "first citizens."

Used throughout this document, the term "American Indian" describes a person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition. Washington State is home to 27 federally recognized tribes. All except one own land and operate health care programs. Tribal enrollments range from less than 150 to more than 8,800. Approximately half of the nearly 107,000 American Indians living in Washington (about 2% of the total state population) reside on reservations, and the majority of the rest are concentrated in the urban areas of Seattle/Tacoma and Spokane.

The Need: Clear and Compelling

American Indians in Washington State have many significant health problems, including a higher burden of serious disease, premature death, and poorer birth outcomes than the population as a whole. The only racial group in Washington experiencing higher death rates and lower life expectancy than American Indians is African Americans. Both American Indians and African Americans have rates of major causes of death, serious infectious disease, and infant mortality that are significantly higher than rates for whites and Asian Americans. The poor health of many American Indians is directly related to the socioeconomic characteristics of tribal communities and the common predicament of low income levels that contribute to poor housing conditions, unhealthy behaviors, and adverse environmental conditions.

American Indians living in Washington State have an age-adjusted death rate higher than that of the population as a whole. The higher total death rate for American Indians is attributable mainly to particularly high rates of death from motor vehicle crashes, stroke, liver disease, diabetes, suicide, and homicide. Crowded living or child care conditions, unchlorinated water supplies, and inadequate sewage disposal have contributed to higher rates of several communicable gastrointestinal diseases compared to the general population. The disease rates for tuberculosis and other respiratory infections among American Indians also are significantly higher. Some research has found that, after controlling for age and stage at diagnosis, American Indians have significantly poorer five-year survival rates compared to whites for the following cancers: cervical, 80% poorer; prostate, 50% poorer; breast, 40% poorer; colorectal, 20% poorer.

***Indian Health Service (IHS)**: The federal agency with responsibilities to provide health services to eligible American Indians.*

***Indian health system**: Those entities operated by the IHS, tribes, and urban Indian health programs that provide health services to American Indians.*

Despite these health problems, American Indians, as a population, have limited health care resources, and all too often, difficulty accessing available services. The Indian health system in Washington State is a fragile, underfunded network. Most American Indians living on or near reservations receive services at tribal or Indian Health Service clinics. Some tribes provide only basic services while others provide a full range. In many areas, the delivery of health is hampered by the poor condition, age, and inadequate size of facilities, or by the difficulty of obtaining needed equipment. Urban programs provide care to a broader segment of the American Indian population including unaffiliated American

Indians, members of non-federally recognized tribes, and descendants of American Indians who are not recognized by the federal government.

Many persons may ask why American Indians can't simply use mainstream or "Western" health care services. For some American Indians, geographic isolation, lack of transportation, and economic factors are barriers. For many, culturally rooted differences can pose significant barriers to accessing mainstream services. Important factors are language and communication styles, family values and structure, tribal lifestyles, and spiritual beliefs. Mainstream health services, which are predicated on dominant cultural assumptions, are often unacceptable to and sometimes ineffective for many Indian people. A high probability for misunderstanding and alienation occurs when mainstream providers are unfamiliar with tribal lifestyles, family values, or communication styles.

Legislative Mandate

American Indian Health Care Delivery Plan (RCW 43.70)

Consistent with funds appropriated specifically for this purpose the department (Department of Health) shall establish in conjunction with the area Indian health services system and providers an advisory group comprised of American Indian and non-Indian health care facilities and providers to formulate an American Indian health care delivery plan. This plan shall include:

1. *Recommendations to providers and facilities methods for coordinating and joint venturing with the Indian health services for service delivery;*
2. *Methods to improve American Indian-specific* health programming; and
3. *Creation of co-funding recommendations and opportunities for the unmet health services programming needs of American Indians.*

The Mandate: A Convergence of History, Responsibility, and Need

Some responsibilities of government entities for American Indian health are clear. The federal government holds treaty obligations extending from 1831 through current Congressional mandates and funding appropriations. State and local governments assume responsibilities to the residents living within their jurisdictions. American Indians, however, are more than simply residents of a nation, state, county, or city. Most also are members of a tribe. Of Washington's 36 tribes, 27 are federally recognized as sovereign governments. This status adds a unique element of complexity to the planning and provision of health services. (See map of Washington's tribes on page 7.)

The 1989 Centennial Accord between the federally recognized American Indian tribes and the state of Washington provides a framework for the government-to-government relationship and implementation procedures to ensure its execution. However, the current statutory definition of Washington's public health system does not include tribes and their lands and, thus, leaves a significant gap in the statewide system.

The belief is widespread among the general populace that the Indian Health Service (IHS) under the U.S. Public Health Service adequately provides for the health care needs of all American Indians. This

significant misconception, compounded by IHS funding constraints, limited resources, and the complexity of delivering services to a widely scattered and diverse population, results in additional barriers to providing services to American Indians who depend on these programs. Furthermore, responsibilities for providing health care services to American Indians have shifted as the federal government has transferred increasing authority and funding to the tribes through self-determination provisions that allow for more flexibility for tribes to design and manage programs that better meet the needs of their members, without abrogation of the federal government's trust responsibility. In an effort to address problems, the IHS, state and local agencies, and tribal health jurisdictions are attempting to redefine their responsibilities and areas of cooperation within this complex situation.

The result, on the positive side, is that individual tribes have seized the initiative and marshaled IHS and other resources to develop many creative programs to address the health problems of their people. Despite differing configurations, the tribes share a uniform pride in their roles in building and directly providing culturally appropriate, accessible health services. Yet, on the negative side, resource limitations mean that many urgent needs cannot be fully met by the tribes.

Thus, although American Indians comprise only 2% of Washington's population, their significant health care needs and unique legal status merit public attention. The Legislature concurred and passed 1995 amendments (RCW 43.70; see sidebar) to the 1993 Health Services Act that directed the Department of Health to formulate an American Indian Health Care Delivery Plan. The department has done so with the assistance of an advisory group of Indian and non-Indian health care providers and representatives of tribal, state, and local organizations. The plan fulfills that legislative mandate and the goals set forth by the advisory group to "... document American Indian ... health care problems and needs, identify barriers, present recommendations to meet those needs, and define strategies ... to enhance the quality of health services and health status for American Indian ... people residing in Washington."

The need is clear. The mandate is clear. The task, however, is complex.

The Task: Action Through Understanding and Collaboration

The 1994 statewide Public Health Improvement Plan (PHIP) recommends and the 1996 PHIP reaffirms that state and local health jurisdictions recognize the autonomy of tribal governments and their independent authority for carrying out the core public health functions—assessment, policy development, and assurance. The 1994 PHIP further recommends that the Department of Health take a lead role in promoting the collaboration between tribes and local health jurisdictions, including agreement for supporting development of functions and responses to public health emergencies based on a framework of government-to-government cooperation. Tribes, like local health jurisdictions, need to have improved information on health status, health risks, and health resources. They also need the ability to use that information to make

tribal health policy and to engage in effective interventions to protect and improve health.

The American Indian Health Care Delivery Plan has three primary objectives:

1. To understand the health status of American Indians in Washington State.
2. To develop strategies to improve their health status.
3. To close gaps in the provision of health care services.

Meeting these objectives requires close collaboration and partnerships between the state, local governments, and the tribes. Specific tasks will include encouraging greater cooperation between facilities and providers, building tribal and urban health system capacity, and accessing other funding sources to address unmet needs.

Another important step is to understand and incorporate cultural considerations into system development and provision of services. A resilient cultural life still forms the basis of American Indian identity. Many American Indian people live within the boundaries of the Indian world and their social ties are primarily with other Indians. Within the general framework of the "Indian way," each tribe is distinct and unique, with its own beliefs, practices, and societal norms and expectations. Respecting and integrating cultural factors into service provision is necessary to ensure the health of each tribal community. The challenge is not to emphasize differences but to recognize and build upon them to improve coordination between state, local, and tribal jurisdictions.

The Recommendations: Strategies to Close the Gaps

Identifying strategies to improve the health status of Washington State's American Indians is the goal of this plan. The following recommendations provide strategies to state agencies, tribes, Indian organizations and others to meet the plan's goal. These recommendations are that:

1. The state recognize, support, and build upon the existing Indian health system.
2. The Indian health system be recognized by the governor, Legislature, and state agencies, and supported as a critical part of the rural health care system of our state.
3. American Indians must have equal access to state health programs that support their freedom of choice in using Indian health programs.
4. State health care dollars be distributed to support the Indian health system toward achieving equity for American Indians. This would include but not be limited to 100% FMAP (federal medical assistance percentage) for Medicaid services provided by tribal facilities.

5. The Centennial Accord be implemented in the area of health by:

   a) requesting that the governor issue an executive order directing state agencies with health-related responsibilities, such as the Department of Health, Department of Social and Health Services, Health Care Authority, Labor and Industries, Department of Corrections, Department of Ecology, and other appropriate state agencies to formalize government-to-government relationships with the tribes,

   b) and effectively involving tribes in all aspects of state health policy affecting American Indians.

6. The Department of Health, Department of Social and Health Services, Health Care Authority, Office of the Insurance Commissioner, and the Indian health system convene a meeting among appropriate entities to identify situations where Indian health programs are prevented from collecting patient reimbursement and to eliminate collection barriers.

7. The state ensure that American Indians are involved in the development of state policies for provider criteria for Medicaid, Basic Health Plan, mental health services, and other state-funded health programs.

8. The state ensure that the option of Basic Health Plan sponsorship continues and that funding is expanded.

9. State agencies and contractors provide technical assistance to the Indian health system and collaboratively work to establish effective partnerships for delivering services to American Indians.

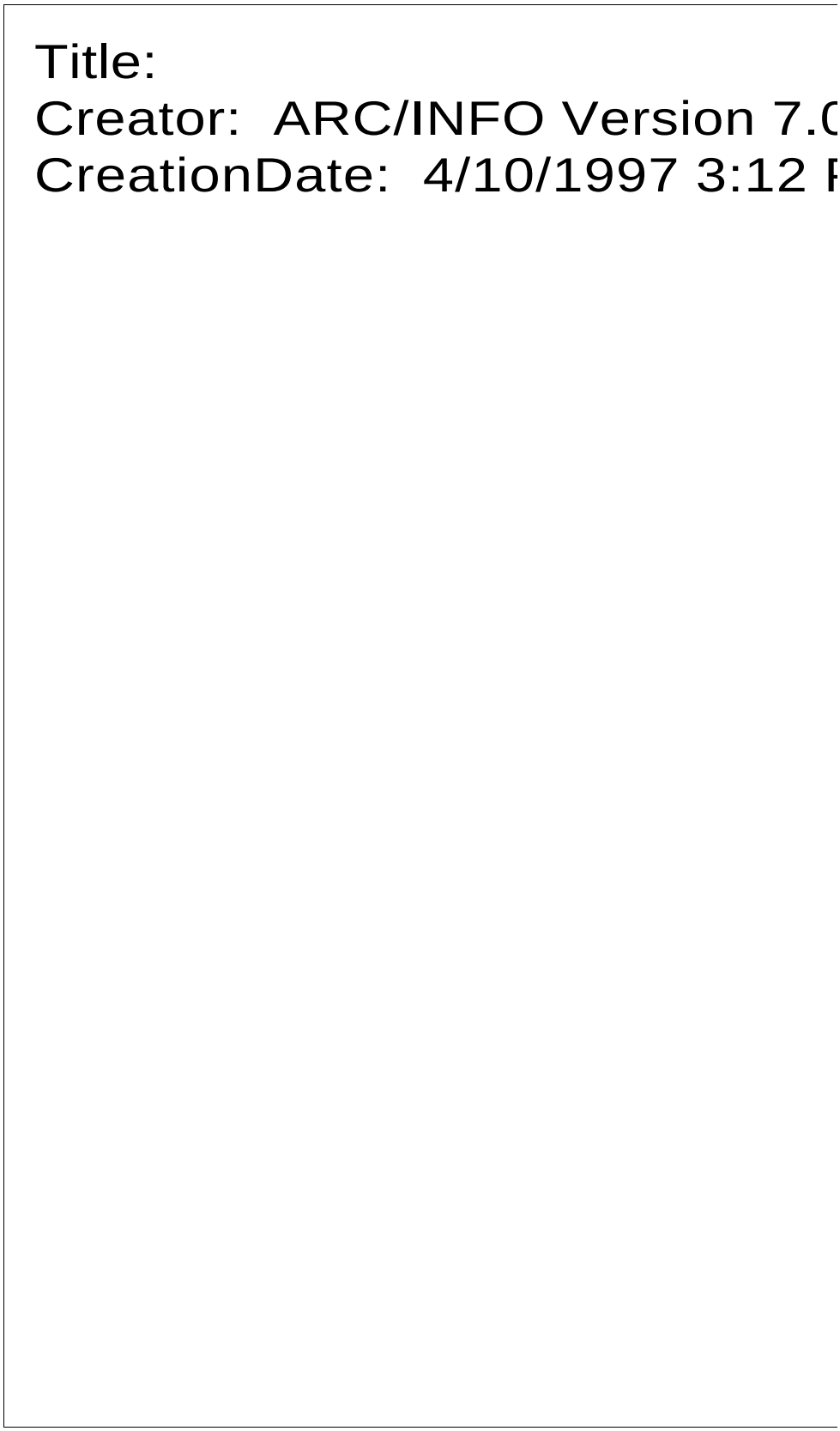
10. The tribes and state negotiate a permanent, mutually agreeable definition of tribal health jurisdiction for the Public Health Improvement Plan.

11. The Legislature provide funding to continue American Indian health care delivery planning and to implement the findings and recommendations.

12. The Department of Health and Indian health system work collaboratively to improve the availability and accuracy of American Indian data by supporting the work of the American Indian Data Committee and funding the proposed American Indian data clearinghouse.

13. The Department of Health commission a study to identify the impact that managed care trends in Washington State will have on the Indian health system revenues, and identify alternative strategies for mitigating the impact.

14. The state and the Indian health system develop effective ways to increase enrollment of Medicaid-eligible American Indian children.
15. The state work collaboratively with the Indian health system to identify issues associated with current certification and licensure barriers and propose recommendations for resolving impediments for the Indian health system.
16. The state collaborate with the Indian health system to develop standards for core public health capacity and state public health resources be allocated to assist tribes implementing those standards.
17. The governor reinstate the state-tribal relations training program by the Office of Indian Affairs and provide specific training to state employees on American Indian health issues.
18. The Department of Health enhance the communication capacity of the Indian health system by linking the Indian health system to the Information Network for Public Health Officials (INPHO) system.
19. Providers of health services to American Indian populations recognize and facilitate access to appropriate traditional Indian healing practices consistent with the client's cultural orientation.
20. Insurers consider the value of traditional Indian healing and, where applicable, provide reasonable compensation.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